STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED			
FCL026008		B. WING		05/06/2016			
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00.0	0/2010
MCLEOD FAMILY CARE CENTER OF FAYETTE 248 LIVERMORE DRIVE							
WICLEOD	FAMILI CARE CENT	TER OF FATETTE	FAYETTE	VILLE, NC 2	8314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCII / MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
C 000	Initial Comments			C 000			
	Report by Rick Ben	ton					
	DHSR Construction Section conducted a Biennial Survey on May 6, 2016 from 2:15pm to 3:45pm at the above referenced facility. DHSR records indicate the home was first licensed on March 16, 1989 for six (6) ambulatory Residents (able to evacuate and respond without any physical or verbal assistance during a fire or other emergency). Based on this information we are requiring the home to maintain compliance with the following: the 1984 (1987 Revision) Family Care Homes - Minimum Standards and Regulations, the applicable portions of the 2005 Rules 10A NCAC 13G for Family Care Homes, and the 1978 (Rev 9) North Carolina State Building Code - Section 409.1(g) - Residential Care Homes. At the time of our visit, we cited deficiencies that require an acceptable plan of correction. They are as follows:						
C 174	Building Equipment Maintained Safe, Operating		C 174				
	SECTION .0300 - T 10A NCAC 13G .03 EQUIPMENT (a) The building ar mechanical, and plu care home shall be operating condition (j) This Rule shall family care homes. This Rule is not me	BUILDING SE and all fire safety, ele umbing equipment i maintained in a saf apply to new and ex	ctrical, n a family e and				
	1) During the surve deficiencies were o a) The range hood	bserved:	•				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED				
FCL026008		B. WING		05/06/2016				
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
MCLEOD	FAMILY CARE CENT	FR OF FAYETTE	RMORE DRIN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE		
C 174	Continued From pa	ge 1	C 174					
	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)							
	necessary repairs.							

4) During the survey of main hallway bathroom,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: 01		COMPLETED			
		FCL026008		B. WING		05/0	6/2016
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE, ZIP CODE		
TWINIE OF F	NO VIDEN ON OUT LIEN			RMORE DRIN			
MCLEOD	FAMILY CARE CENT	TER OF FAYETTE		VILLE, NC 2			
	0.0000000000000000000000000000000000000			<u> </u>			
(X4) ID PREFIX		TEMENT OF DEFICIENC MUST BE PRECEDED E		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFOR		TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
C 174	Continued From pa	ge 2		C 174			
	the following deficie	encies were observ	ed:				
	a) There was a pu						
	base of the toilet wl						
	b) The floor tile wa						
	c) The lower left si						
	vanity cabinet it app	peared to be staine	d or				
	damaged.	٠٠٠٠ - ١٠ - ١ - ١ - ١ - ١ - ١					
	d) The sealant are	und the tollet was s	everely				
	stained. Contact a qualified	technician to make	the				
	necessary repairs. Provide to our office all supporting documents that will verify the completed work.						
	completed from:						
	5) During the surve	ey of resident bedro	om 4, the				
	following deficiencie						
	a) The rear window						
	b) The right side w						
	c) There was no gl						
	Contact a qualified technician to make the						
	necessary repairs. Provide to our office all						
	supporting documents that will verify the completed work.						
	completed work.						
	6) During the surve	ey of resident bedro	om 3, the				
	following deficiency	was observed:					
	a) Behind the entrance door there was a hole in						
	the wall.						
	b) It appears that t						
	enough to remove t						
	the room in his bed						
	non-life-threating m with your contractor						
	measures to ensure						
	and the bed can be						
	the resident from th						
	Contact a qualified technician to make the						
	necessary repairs and/or alterations. Provide to						
	our office all supporting documents that will verify						

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the completed work.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: 01		COMPLETED				
		B. WING						
FCL026008			B. WING		05/0	05/06/2016		
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
				RMORE DRIN				
MCLEO	FAMILY CARE CENT	TER OF FAYETTE		VILLE, NC 2				
				VILLE, NC 2				
(X4) ID		TEMENT OF DEFICIENC		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE	
PREFIX TAG		/ MUST BE PRECEDED I SC IDENTIFYING INFOR		PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE	
1710			- /	17.0	DEFICIENCY)			
C 174	Continued From pa	ge 3		C 174				
	7) During the surve	ay of family room t	he following					
	deficiency was obs		ne lollowing					
	a) The rear exit do		aa aayaraby					
	,	or at the bottom wa	as severely					
	damaged. Contact a qualified	toobnicion to make	tho					
	necessary repairs.							
	supporting docume	nis inai wiii veriiy i	ne					
	completed work.							
	O) During the gume	of the ottic the f	المسامية الما					
	8) During the surve		ollowing					
	deficiency was obs							
	a) The heat detect							
	wirings connecting it that were not enclosed in a							
	junction box.							
	Contact a qualified							
	necessary repairs.							
	supporting docume	nts that will verify t	he					
	completed work.							
	During the surve							
	the following deficie							
	a) The roof area or							
	rear at the chimney had overhanging branches							
	that were in contact with the roof.							
	b) The rear left corner soffit and fascia were							
	severely damaged.							
	c) The exterior sidi	ng on the left side	at the staff					
	entrance appears dirty and has some mildew							
	buildup.							
	d) The exterior siding on the rear side of							
	bedroom 4 appears dirty and has some mildew							
	buildup.							
	e) At the front left side of the porch there was an							
	oak tree that if not taken care of will cause							
	damage to the fascia and soffit in the area.							
	f) The crawl space is not properly fitted with a							
	door and is closed off with a piece of metal that is							
	held in place by brid		-					
	g) On the left side		staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
		FCL026008	B. WING		05/	06/2016
	PROVIDER OR SUPPLIER D FAMILY CARE CENT	TER OF FAYETTE 248 LIVER	DRESS, CITY, S RMORE DRIV VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
C 174	entrance, there is a step to the ground. to help reduce the contact a qualified necessary repairs. supporting docume completed work. 10) During the survey second ramp was repaired to the provider resident that reside non-ambulatory as be required. 10 NO two handicap access requires physical as evacuation. The had constructed in accounting the provider resident that reside non-ambulatory as the required of the provider requires physical as evacuation. The had constructed in accounting in the provider regime to the provider	deep drop off from the last This area should be built up drop off. technician to make the Provide to our office all ints that will verify the vey, it was observed that a not installed on the home. The non-ambulatory residents, one pital bed. During a Complaint is was informed that any d in the home and deemed as econd handicap ramp would CAC 13G .0312 (c) requires esible ramps if any resident	C 174			

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